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All Specialty Boards Committed to Recertification

Studying together in Chicago for recertification examinations given by the American Board of Internal Medicine, Drs. Clifford J. Pilz, Armand Littman, Jay Colbert, and W. Robert Meadows quiz one another in the first voluntary recertification since the medical profession was organized into specialities.

Medical Tribune Report

All 22 speciality boards are now committed to the principle of recertification, a survey by MEDICAL TRIBUNE shows. At least two have adopted plans that eventually will require renewal of certificates.

The first to adopt mandatory recertification was the American Board of Family Practice. The first group of diplomates, certified in 1970, must undergo re-examination in October, 1976.

The procedure will consist of evidence of continuing education (300 hours over the six-year period), an appraisal of the professional character of the candidate, a cognitive examination, and a review of office records.

The 4,000 diplomates of internal medicine who on October 26 took the first voluntary recertification since the medical profession was organized into specialities almost 60 years ago, will receive their confidential scores between February 1 and 15, according to Dr. Palmer H. Futcher of Philadelphia, executive director of the American Board of Internal Medicine.

"We estimated that 16,000 certified internists were eligible, so that the

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Intractable Enteric Bacillus Menaces U.S. Burn Centers

Burn patients are particularly vulnerable to Providencia stuartii, a previously obscure enteric bacterium.

Medical Tribune World Service

BUENOS AIRES—Providencia stuartii, a rampaging, enteric bacterium, apparently resistant to all known antibiotic agents, may be the next infective agent to sweep through burn centers in the United States. It has invaded burn wounds, caused pneumonia, and often, fatal septicemia.

This frightening warning was voiced here by a group of investigators from one of the United States' leading burn treatment and research centers. Drs. R. B. Lindberg, A. D. Mason, Jr., and B. A. Pruitt, Jr., of the U. S. Army Institute of Surgical Research at Fort Sam Houston, Texas, reported on the uncontrollable pathogen at the 4th International Congress on Burn Injuries, here.

Since 1969, Dr. Lindberg said, there has been a marked rise in bacteremia, sepsis, wound colonization and invasion, and pneumonia caused by Providencia stuartii. And there has been a concurrent increase in mortality

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Misdiagnoses Snag Sicklemia Screening Plans

Medical Tribune Report

SANTA MONICA, CALIF.—Community screening programs for sickle cell anemia, as they are now set up, may be doing more harm than good, according to Dr. James E. Bowman, director of the Comprehensive Sickle Cell Center at the University of Chicago.

"In Chicago we spend most of our time trying to straighten out people who have been misdiagnosed by community screening programs," the black physician told a conference on sickle cell diseases sponsored by the Intra-Science Research Foundation here.

Misdiagnoses of the sickle cell trait —that is, the possession of a single gene for sickle cell hemoglobin in otherwise normal individuals—have led to unnecessary doubts about parentage, difficulties in getting jobs, and, in some cases, computer readouts that lump the sickle cell trait with the disease itself, he said.

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making rounds — at press time

STEEL PLANT RISK - A study to be completed later this year of the details of the deaths of 361 employees of a Md. steel plant is showing 47% more than expected deaths from stroke, 43% more from cancer (lung, leukemia, and bladder ca leading), and higher respiratory disease deaths, according to Dr. Edward P. Radford, Prof. of Environmental Med. at Johns Hopkins School of Hygiene and Public Health. Mortality rate studies and specific occupational breakdowns are pending.

55 MPH -- "After a year of trying it out, the 55 mph speed limit looks like the safe thing to do." Dr. Alexander Hering, Assistant Director of the American College of Surgeons Trauma Division, said in reference to the bill signed by the president Jan. 4. "Not enough time has elapsed to get the full statistics but we know there have been fewer deaths since people started slowing down."

MEDICAID - A Government Accounting Office study of Medicaid in Ill. is expected to be sent to the Senate Finance Committee next month. Report grows out of accounts of overcharging by factoring firms collecting on behalf of MDs.

Inoperable Lung Cancer Eludes VA Therapy

Medical Tribune Report

CHICAGO—After 16 years and 13 sequential, controlled studies with nearly 2,000 male patients in 26 Veterans Administration hospitals, the goal of extending life in patients with localized but inoperable or nonresectable lung cancer has proved "elusive" and the odds for survival are "grim."

This assessment was presented to the Radiological Society of North America by the chairman of the Veterans Administration Lung Cancer Group (VALG), Dr. Julius Wolf, who is also chief of staff at the VA hospital in the Bronx, N. Y.

Only 48 (3.8 per cent) of 1,279 such patients in the first eight studies lived two years after beginning therapy, Dr. Wolf said.

In the 13 studies, radiation therapy was randomized with an inert compound and with alkylating agents, androgenic agents, and the nitrosoureas. In the first seven studies, an inert compound was used as a therapeutic control. In subsequent studies, radiation and cytoxan were used as the "reference regimen."

Small Beneficial Effect

Dr. Wolf reported that radiation therapy (notably supervoltage), alkylating agents (principally cytoxan and nitrogen mustard), and the nitrosoureas (particularly CCNU and BCNU have "a significant but distressingly small beneficial effect on survival" when used alone or in combinations in patients with "limited disease." Limited disease was defined as "inoperable or nonresectable tumor limited to one hemithorax, without distant metastasis, and of a dimension which can be completely encompassed in a reasonable treatment volume." All other patients were considered to have "extensive disease."

Radiation therapy consisted of a tumor dose between a minimum of 4,000 rads (minimum) and a maximum of 5,000 rads delivered in daily fractions of 150-200 rads, five days per week, in four to five weeks.

Dr. Wolf said it was "of unusual interest" that "the clinical condition of the patient at the outset—the initial performance status—proved to be one of the most reliable predictive factors in prognosis. There was a consistent linear relationship between long survival and the performance rating."

The survival benefit of radiation was better in all studies, Dr. Wolf said, but the effect was seen only in patients with squamous cell tumors and adenocarcinoma.

"Patients with undifferentiated small cell tumors did not benefit in survival through radiation therapy," Dr. Wolf said, "despite the fact that their local tumor response was often striking."

The effect of cytoxan and nitrogen mustard on life span was comparable to radiation therapy, Dr. Wolf said, but he pointed to a "unique" cell-type correlation seen in the response of the agents.

"Patients with poorly differentiated cancer survived longer with cytoxan treatment, while those with squamous lesions did best with nitrogen mustard."

The favorable effect of cytoxan compared to radiation was "persistent" and prompted the testing of radiation and cytoxan against radiation alone. The combination resulted in the best median survival time, 33.7 weeks, but only for squamous cell cancer.

13th Study in Progress

Protocol 13, begun in April, 1972, is testing radiotherapy plus CCNU (100 mg./M² orally every six weeks) and hydroxyurea (1 gm./M² orally two times a week) against radiotherapy alone. There are now nearly 200 patients in the 13th study, Dr. Wolf reported, not yet enough for a significant statistical assessment.

"Clearly," Dr. Wolf said, "local therapy such as surgery or supervoltage radiation can only be expected to influence the survival of patients with sharply limited local disease of a well-differentiated cell type, and demonstrating a high initial performance status.

"Unhappily," he continued, "the majority of patients with bronchogenic carcinoma, when first seen, are already inoperable because of extensive local disease and metastases, or prove to have non-resectable tumor on thoracotomy.

"Occult disease, both local and extra-thoracic, must surely have been far greater than the visible portion if we are to explain the poor results of radiotherapy," Dr. Wolf said.

Data from 4,000 autopsies showed that 94 per cent of patients with undifferentiated small cell cancer die with disseminated disease, while 56 per cent of squamous cell carcinomas and 11 per cent of adenocarcinomas remain localized until the patient's death.

"Systemic chemotherapy, in alliance with local radiotherapy," Dr. Wolf said, "would appear to have a better chance of slowing growth and prolonging life.

"However, all of these agents we have tried have had only a minimal and transient effect similar to radiation therapy. It has become perfectly clear as experience has demonstrated with other solid tumors, that more combination chemotherapy regimens must be fashioned and tested, using more effective agents with different actions and toxicity," he said.

Black MD Would Halt Use of Poor In Clinical Trials

Medical Tribune Report

WASHINGTON—A black physician who has been pondering the use of poor patients in clinical experimentation thinks perhaps it should be stopped, at least for enough time to establish some safeguards.

Dr. Henry W. Foster, chairman of obstetrics and gynecology at Meharry Medical College in Nashville, told a news conference here that exemption of the poor from human experimentation is "an alternative that no one has suggested" to counter such situations as the Federal syphilis study in Tuskegee, Ala., in which poor, black, male patients were denied treatment for 40 years.

The clandestine aspect of that study, Dr. Foster indicated, was pointed up by the circumstance that "when that story broke, I was president of the Macon County Medical Society in Tuskegee and I'd never even heard of the study."

Planning for Forum

He and two other physicians were here to plan their part of the program —directed toward the plight of the poor—in a two-day forum on human experimentation, which will be sponsored by the National Academy of Sciences Feb. 18-19. Dr. Foster said that his idea of a moratorium on the use of poor people in medical experiments is only "my strong consideration now; I hope to make it firmer by the time of the February forum."

His colleagues on the panel did not completely agree with the concept. Dr. Franz J. Inglefinger, editor of the *New England Journal of Medicine*, said that exempting the poor might "deprive them of studies theoretically related to their benefit." He questioned, for instance, "how can you improve the vaccination rate for infectious diseases in a poor area without studying the causes for the low rate among the poor?"

Dr. Jay Katz, co-director of the law, science, and medicine program at Yale Law School, also believes that the poor have a large stake for benefit from clinical trials. He noted that "not to experiment with them is also an experiment." Exempting them from experiments, he said, poses dangers of "creating new groups of poor people" who are then "put on waiting lists" for therapy that they urgently need.

But Dr. Katz also said that, from a standpoint of better informed consent, "should not our most knowledgeable and advanced persons be chosen?" He suggested that lotteries or "drafts" of the more privileged patients might have to be conducted to get them into experiments "if society wants it badly enough." He cited an article in a 1968 issue of the *New England Journal*, whose authors found that, for a hypothetic experiment requiring the subject to be infected with malaria, two-thirds of prisoners said they would participate but absolutely no professionals would.

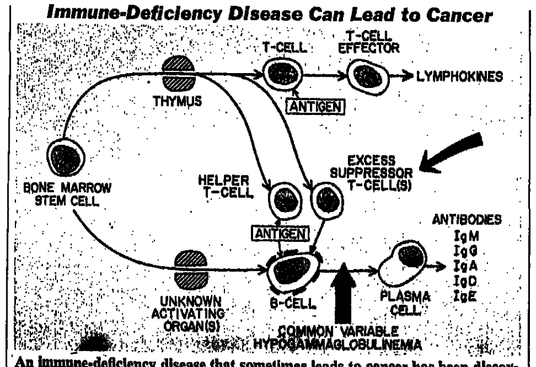
All three panelists believe that human experimentation is needed for medical advances. They also expressed a variety of doubts about the validity of present procedures for obtaining informed consent from a patient. Dr. Inglefinger said that true informed consent "doesn't exist unless the patient is a physician in virtually the same field."

Psychological Reorientation

Dr. Katz said that improvement in informed consent requires the investigator "to psychologically reorient himself to accept the subjects almost as co-investigators, with the right to say yea or nay."

Dr. Foster indicated that that was precisely that kind of improvement in experimentation that he would like to see established before the poor were brought back into the clinical trial picture.

Immune-Deficiency Disease Can Lead to Cancer



An immune-deficiency disease that sometimes leads to cancer has been discovered by Dr. Thomas Waldman and National Cancer Institute colleagues. Above, drawing shows the complex mechanism of antibody failure in common variable hypogammaglobulinemia (CVH). The large arrow at bottom indicates blockage in normal B-cell maturation into antibody-producing plasma cells. Excessive "suppressor" T-cell production adversely effects B-cell maturation; excessive "suppressor" T-cells are linked to CVH which sometimes results in cancer.

Medicine Said To Fail In Its Use of Nutrients

Medical Tribune Report

NEW YORK—Medicine has generally failed to use nutrients as therapeutic or preventive tools in health care, Dr. Willard A. Krehl, Professor and chairman of the Department of Community Health and Preventive Medicine at Jefferson Medical College, said here.

Speaking at a Nutrition and National Priorities Seminar for Editors and Writers, sponsored by the Vitamin Information Bureau, he cited, as an example of this failure, results of a survey of 35 patient charts selected at random at his own institution. He found that although 14 patients had diabetes, in which "we would presume that a certain caloric level based on height and weight should be established," only seven charts listed weight and four height, and there was a complete failure to record food intake.

House Staffers Win 'Rights' In AMA in 3-Hour Walkout

Medical Tribune Report

PORTLAND, ORE.—For three cliff-hanging hours, the American Medical Association lost its young physicians as leaders of 5,000 house staffers walked out in anger at the A.M.A.'s convention here.

They charged the association's leadership had treated them with contempt, refusing to give them jurisdiction over their own affairs within the A.M.A. Further, they charged, the Board of Trustees was planning to flout a just-passed House resolution calling for such rights.

Three hours later, after a hastily convened quorum of the Board of Trustees met their demands, the young physicians returned and informed the relieved House of Delegates they were coming back to the fold.

"We can now serve the A.M.A.," Dr. David A. Axelrad of Fort Ord, Tex., a spokesman for the group, told a press conference—the second that day. "We are withdrawing our resignations and will attempt to make the A.M.A. a force for progress in this country."

Dr. Axelrad, a psychiatrist in the Army Medical Corps, and Chairman of the A.M.A.'s Interns and Residents Business Session (I.R.B.S.), said he would call on the nation's estimated 55,000 house staffers "to join the AMA and help make it a progressive influence for health care."

At issue in the emotion-filled out-again in-again episode was the 2½-year-old demand by the I.R.B.S. that its elected officers be recognized as the advisory council of the Board of Trustees on matters affecting young physicians. They called on the A.M.A. to abolish the existing House Staff Council, composed of members appointed by the Board as advisory liaison.

'Meaningful Participation'

Dr. Axelrad and his colleagues made it clear before the convention opened that "meaningful participation" (the slogan of their campaign) had become a make-or-break issue, and warned they would resign if this demand were not met. Adding muscle to their threat was the fact that the A.M.A. house staff members had gone on record as agreeing to resign en masse if the demand were rejected at the Portland convention.

Adding even more muscle was the fact, demonstrated in the House of Delegates vote, and in speeches at committee meetings, that a large majority of the older A.M.A. delegates were on the house staff side.

Dr. Robert Harmon of Los Angeles, President of the Physicians National House Staff Association, told the convention: "We are seeking a legitimate input based on our rights. We want evidence of ongoing good faith by the A.M.A. in responding to the initiatives of young physicians."

A California resolution, embodying the demands of the young physicians, and backed by the New York, Wisconsin and other delegations, was approaching approval in the House after several hours of debate, when Dr. Carroll N. Witten, Chairman of the Committee on the Constitution and By-Laws, arose to question whether the House had the authority to call for the dissolution of any existing committees, or create new ones. The California resolution had called for elimination of the Committee on House Staff Affairs, its responsibilities to be vested in the I.R.B.S. The House agreed to hold its vote in abeyance until the committee could report.

House Overrides Committee

The following day, the Committee on the Constitution dropped its bombshell. Dr. Witten told the House it had no authority to instruct the Board of Trustees to create new committees or specify their duties.

One angry delegate declared: "In that case, maybe we should have stood in bed."

The House over-rode the Committee on the Constitution and By-Laws and passed the California resolution. But at this point, Dr. Axelrad and his colleagues stalked out of the meeting to read a prepared statement to a press conference, announcing their own resignations and that of all house staff members of the A.M.A.

Dr. Axelrad denounced the action of the Constitution Committee as a "cheap shot" at the young physicians, and said it only confirmed their suspicion that the Board of Trustees was maneuvering to frustrate the will of the House.

"The entire control of the A.M.A.," said Dr. Axelrad, 'is under the 15 men, far removed from reality, who make up the Board of Trustees."

He refused pleas by dismayed older physicians, who had supported the resolution, to avoid hasty action. The turning point came when Dr. Russell B. Roth, A.M.A. President and Dr. Richard E. Palmer, Chairman of the Board of Trustees, entered the press conference and gave Dr. Axelrad and his colleagues their personal assurances that they would review the recommendation of the California resolution that very day. On that assurance, Dr. Axelrad said the resignations would not be withdrawn but held in abeyance until the board reported back.

Mandate Satisfied

Three hours later, Dr. Roth was given the floor to make a special announcement to the House. He said: "A quorum meeting of the Board of Trustees has agreed to dissolve the House Staff Council and to approve the appointment of the officers of the I.R.B.S. as the Advisory Committee."

In response, Dr. Rex Green thanked the house for its "tremendous support and said: "Our mandate from the interns and residents has clearly been satisfied." N.H.

Lose Head, Gain Heart

A biological method for controlling the transmittal of malaria by mosquitoes is being studied at the National Institute of Allergy and Infectious Diseases. Robert W. Gwadz, Ph.D., is investigating genetic control of the breeding capacity of Anopheles mosquitoes. Since they will not mate in captivity, Dr. Gwadz removes the head of the male (above) which allows the male to continue to live but removes the nerve center that controls the mating instinct. The removal releases the male's inhibitions and allows the headless male to mate.

Weight and Height Declared Breast Cancer Risk Factors

Medical Tribune World Service

FLORENCE, ITALY—Weight and height are synergistic risk factors for breast cancer and could help to explain the high incidence of this disease in the West, according to a Dutch prospective study covering more than 7,000 postmenopausal women.

The relative risk in women taller than 5 feet 7 inches and weighing more than 132 pounds was in fact more than five times that of women weighing under 132 pounds, Dr. Frits de Waard, of the Department of Epidemiology, University of Utrecht, told the 21st International Cancer Congress here.

High parity counteracted the risk of high weight, he reported and single women showed a reduced risk because of their relatively lower body weight. On the other hand, those with a previous mastectomy faced a fivefold increased risk.

During the study, in which 50 general practitioners followed up 7,259 women for an average period of 5.4 years, there were 70 cases of breast cancer, compared with an expected 76.

Dr. de Waard commented that a correlation between body size and breast cancer is of considerable importance since it may help to explain international variations in incidence. There are many tall and heavy women in Western countries, compared with places like Japan, Taiwan, or Singapore, where breast cancer incidence is low.

ECTOPIC BEAT

One of the odd side effects of the great Tidal Basin affair turned up in an Associated Press dispatch reporting the revival of the undampened Firecracker's ecdysiastic career:

"She said that the current tour would delay her plans to study premedicine at the University of Maryland." First things first.

(Regular beat: Insomnia Medica, page 23.)

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CLINICAL NEWS NOTE: *"The activity of butorphanol in man appears to be ten times more potent than morphine sulfate and 40 times more than pentazocine when injected intramuscularly." (Dr. Allen B. Dobkin, see pg. 4.)*

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Non-Opiate Analgesic, Butorphanol, Seen Promising

Medical Tribune World Service

MEXICO CITY — Preliminary clinical trials of butorphanol, a non-opiate synthetic narcotic antagonist analgesic developed in Canada indicate it could be the strong nonaddictive pain killer that has been sought for generations.

Results of 18 months of testing Butorphanol (levo-N-cyclobutylmethyl-3, 14 beta dihydroxymorphinan) by Dr. Allen B. Dobkin, Professor of Anesthesiology, Upstate Medical Center, New York were presented at the First International Congress of Anesthesiology.

"The activity of butorphanol in man," Dr. Dobkin said, "appears to be ten times more potent than morphine sulfate and 40 times more than pentazocine when injected intramuscularly. These findings are in agreement with the preclinical pharmacological evaluation of the drug in animals. It also has antinarcotic properties of about the same strength as nalorphine which is used to counteract overdoses of such drugs as morphine and demerol."

Dr. Dobkin conducted two double-blind trials comparing it with morphine in 120 patients and with pentazocine in 200 patients who complained of moderate to severe pain usually after major abdominal or orthopedic surgical operations such as cholecystectomy or total hip replacement.

Intensity of pain and relief were scored for each medicated patient at 30, 60, and 120 minutes on a scale of 0 to 3. After tabulation of the data, scores were analyzed statistically.

Blood pressure and pulse rate varied after analgesic medication with a general trend to a small reduction in systolic blood pressure and pulse rate, Dr. Dobkin said, but the changes appeared to be insignificant and appreciably less than these seen with intravenously administered analgesics.

No patient developed evident respiratory depression, euphoria, or hallucinations after any of the medications, he observed. Substantial pain relief was seen in most instances at the 30-minute observation period. Approximately 90 per cent of the patients required no remedication within two hours of the study medication.

The only side effect noted in patients with pain was slight drowsiness. In normal volunteers doses higher than 1 mg. were found to be capable of producing lightheadedness, slight nausea, and unsteady gait.

Animal studies carried out by Bristol Laboratories of Canada, the drug's developer in Syracuse and at the University of Michigan, Dr. Dobkin said, appeared to show physical dependence liability to be low and that butorphanol does not substitute for morphine in the withdrawn morphine-dependent rhesus monkey. The evaluation of butorphanol physical dependence in man is currently under investigation at the Addiction Research Center in Lexington, Kentucky.

14 of 50 Asthmatic Children Found Intolerant to Aspirin

Medical Tribune Report

SAN FRANCISCO—More than one-quarter of a group of children with chronic asthma were demonstrated to have an intolerance to aspirin by a small study done at the University of California, Los Angeles.

Reporting on the study to the American Academy of Pediatrics meeting here, Dr. Gary Rachelefsky stated that "the results of this investigation strongly suggest the importance of eliminating the use of ASA (aspirin) in children with chronic asthma."

Dr. Rachelefsky reported that 14 of 50 children involved in the double-blind study demonstrated significant small airway obstruction after the ingestion of 300 mg. of aspirin. None had a history of aspirin sensitivity or nasal polyps, and all required continuous medication. The group included 34 males and 16 females, ages 6 to 18, who had had extrinsic asthma for at least five years.

Nine of the 14 aspirin-intolerant patients reacted within 30 minutes, one within an hour, and four after two hours, he continued. In addition, four complained of nausea or abdominal cramping, and three had increased nasal discharge.

Intolerants More Likely Female

Dr. Rachelefsky observed that, when compared with the other 36 patients, the aspirin-intolerant group had more females, an onset of disease prior to two years of age, and more episodes of sinusitis. Both groups showed elevated serum IgE levels and total peripheral eosinophil counts. No difference was seen in dependency on steroids, frequency of eczema or nasal eosinophilia.

When the placebo responses were compared with the aspirin responses in all 50 children, the aspirin challenges were found to produce a significant decrease in pulmonary function, Dr. Rachelefsky noted. This difference was seen even when the 14 aspirin-intolerant patients were removed.

Dr. Rachelefsky observed that adults with aspirin-induced asthma appear to be a heterogenous group not distinguished by a particular disease pattern until the third or fourth decade, when intermittent rhinorrhea develops, progressing to chronic nasal blockage and occurrence of nasal polyps, and later asthma, which is resistant to the usual medications and requires steroid treatment for control.

The present study, he said, "suggests that intolerance may develop before adulthood, even without nasal polyps or severe nasal symptoms," and may be a different entity than the adult disease.

Dr. Rachelefsky suggested that intolerant patients may fail to make an association between ingestion of aspirin or an aspirin compound and a provoked or intensified asthma attack because of the delayed reaction.

Also, he continued, many compounds contain aspirin or other compounds known to precipitate asthma in aspirin sensitive patients, unknown to the patient. In this latter group he included indomethacin, mefanamic acid, tartrazine (a yellow coloring material used in soft drinks), canned vegetables, and some medications.

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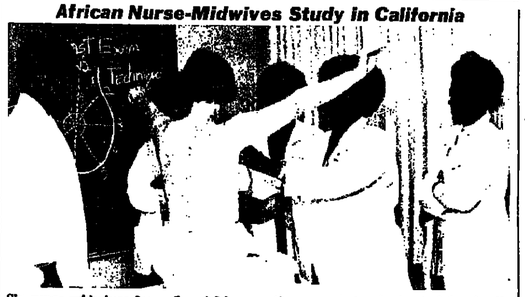
African Nurse-Midwives Study in California



Six nurse-midwives from five African nations are intensively studying family planning, women's health, and child care at Harbor General Hospital in Torrence, California in order to apply modern methods to their native countries. Above, Mrs. Hope Simelane from Swaziland practices examination techniques for breast cancer while the other students look on.

Current Opinion

This Is Medical Ethics?

By DR. CHARLES B. MOORE
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Excerpted from the Hastings Center Report of the Institute of Society, Ethics and the Life Sciences, Hastings-on-Hudson, N.Y. 10706

WHAT IS the field of medical ethics and how should it be defined? The physician has tended to be concerned with the practical, with what can actually be accomplished, with those things that are known and from which he feels that he should be able to adduce the future. The ethicists have tended to look toward the ideal, to consider the meaning of life, the importance of the sanctity of life, the ultimate meaning of man's existence, and the role of the individual in this world. The obvious link between the two fields is that they both hope to accomplish the same goal—improved medical care for the patient, administered ethically.

Following an exposure of one year to Moral Theology as a Kennedy Fellow in Medical Ethics, I must say that, from the view of the practicing physician, most of the conversations I have had with ethicists have tended to anger me, producing a feeling of deep frustration. Too often in the past dialogues between ethicists and physicians have included mostly those physicians in special situations such as primary, non-therapeutic research, or whose interests tended toward those of the ethicists. Thus, about 95 per cent of the practicing physicians were excluded from any significant encounter and from any guidance from those trained in ethics. A more productive way would appear to involve meaningful dialogue as the two disciplines attempt to approach each other openly.

The subjects which follow are areas of interest to the ethicist which seem to have little relevance for the average physician. Emphasis on these subjects can only fail to produce any significant response from most physicians.

Informed Consent. Informed consent is a vital question for those physicians involved primarily in research, but they represent only 2.86 per cent of the physicians in this country (as of the 1970 census). For the remaining 97.14 per cent, the problem is to be certain that the patient has been told enough of the facts before grabbing the consent form from the doctor's hand and signing it. Ethicists' concern is to be certain that the patient is always protected from any abuse by the physician, but since most decisions are based on medical facts possessed and supplied by the physician, the problem more commonly is whether the physician has been coerced into a situation by the enthusiasm of the patient. One must realize that the physician is ultimately the one who makes the decisions in most instances and the problem is to know how much information is needed to protect the patient and his family from themselves.

Organ Transplantation. Admitting the bad experience with heart transplants, but having seen the good outcome of renal transplants and the hopeful results with certain other organs, most physicians still react favorably to the question of continued study and utilization of organ transplants. To this end, the acquisition of organs acceptable for transplantation should be a part of the routine procedures instituted as the death of a patient approaches. Protection for the dying patient must be insured by committees and by standard legal criteria. A clear legal, ethical and medically acceptable definition of death is vital. It may be that the ideal transplant arrangement would not require the permission of the donor or next of kin, but rather only a specific disapproval in selected cases.

Abortion and Contraception. This really should be considered a religious rather than a medical problem. Admitting that the ethics of the practice of medicine must be guided by the religious convictions of the individual physician, I still cannot consider these subjects as areas for the field of medical ethics. The problem for the individual physician is whether or not he or she does abortions and provides information on contraception. The problem for medicine is how to arrange in a safe and economical manner to provide abortions and contraceptives for all who need them.

Drug Research. It is vital to separate the therapeutic or *possibly* therapeutic from the non-therapeutic study of drugs. Most physicians encourage their patients to participate in clinical drug testing and, even when the research is only potentially therapeutic, the most common problem is how to restrict the number of voluntary participants. As the beneficiaries of fifty years of successful drug discoveries, most physicians encourage evaluations of drugs with possible desirable effects for specific diseases. Since most patients involved in these studies are suffering from the disease that the new agent aims to alter beneficially, and since animal work will have been done previously, no ethical problems arise. If anything, I suspect that a large number of physicians would feel that the Federal Drug Administration's requirements for drug testing are much too stringent and unrealistic.

Reproductive Research. This includes artificial insemination (both donor and homologous), fetal research, in vitro fertilization, artificial placentas, and both positive and negative eugenic approaches. Problems raised by this type of study seem to be more legal in nature than medical. The general attitude of the physician is that we must continue to learn all that we can about these procedures and attempt to apply them successfully in our daily lives where indicated. Few physicians would be willing to fold their hands and wait for the genetic "end-days" without at least attempting

DR. MOORE

to solve more of the problems. It is probably here, more than on any other subject, that the ethicist and the physician would part company.

"Right" to Medical Care. I do not believe that many physicians would agree with the statement that everyone has a "right" to equal medical care in all respects. Most would probably say that there is a right to a certain minimal medical care, and an additional right to purchase superior care if one can afford it. That this second consideration exists as a desire is shown by the continued presence of private practitioners in England, where socialized medicine has been in existence for approximately 25 years. Many choose to pay the added price to have a famous physician care for them.

What is the minimal medical care that one may expect? The care given in the charity hospital systems of this country may serve us an example. The problem then becomes one of how to see to it that those families whose income excludes them from charity care receive comparable service. Achieving the level for all then becomes a problem of economics and politics more than anything else.

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Text: Dr. Joseph Klor
Stamp: Minkus Publications, Inc., New York

Current Opinion

This Is Medical Ethics?

By DR. CHARLES B. MOORE
Department of Internal Medicine
Alton Ochsner Medical Foundation
and Ochsner Clinic, New Orleans

Excerpted from the Hastings Center Report of the Institute of Society, Ethics and the Life Sciences, Hastings-on-Hudson, N.Y. 10706

WHAT IS the field of medical ethics and how should it be defined? The physician has tended to be concerned with the practical, with what can actually be accomplished, with those things that are known and from which he feels that he should be able to adduce the future. The ethicists have tended to look toward the ideal, to consider the meaning of life, the importance of the sanctity of life, the ultimate meaning of man's existence, and the role of the individual in this world. The obvious link between the two fields is that they both hope to accomplish the same goal—improved medical care for the patient, administered ethically.

Following an exposure of one year to Moral Theology as a Kennedy Fellow in Medical Ethics, I must say that, from the view of the practicing physician, most of the conversations I have had with ethicists have tended to anger me, producing a feeling of deep frustration. Too often in the past dialogues between ethicists and physicians have included mostly those physicians in special situations such as primary, non-therapeutic research, or whose interests tended toward those of the ethicists. Thus, about 95 per cent of the practicing physicians were excluded from any significant encounter and from any guidance from those trained in ethics. A more productive way would appear to involve meaningful dialogue as the two disciplines attempt to approach each other openly.

The subjects which follow are areas of interest to the ethicist which seem to have little relevance for the average physician. Emphasis on these subjects can only fail to produce any significant response from most physicians.

Informed Consent. Informed consent is a vital question for those physicians involved primarily in research, but they represent only 2.86 per cent of the physicians in this country (as of the 1970 census). For the remaining 97.14 per cent, the problem is to be certain that the patient has been told enough of the facts before grabbing the consent form from the doctor's hand and signing it. Ethicists' concern is to be certain that the patient is always protected from any abuse by the physician, but since most decisions are based on medical facts possessed and supplied by the physician, the problem more commonly is whether the physician has been coerced into a situation by the enthusiasm of the patient. One must realize that the physician is ultimately the one who makes the decisions in most instances and the problem is to know how much information is needed to protect the patient and his family from themselves.

Organ Transplantation. Admitting the bad experience with heart transplants, but having seen the good outcome of renal transplants and the hopeful results with certain other organs, most physicians still react favorably to the question of continued study and utilization of organ transplants. To this end, the acquisition of organs acceptable for transplantation should be a part of the routine procedures instituted as the death of a patient approaches. Protection for the dying patient must be insured by committees and by standard legal criteria. A clear legal, ethical and medically acceptable definition of death is vital. It may be that the ideal transplant arrangement would not require the permission of the donor or next of kin, but rather only a specific disapproval in selected cases.

Abortion and Contraception. This really should be considered a religious rather than a medical problem. Admitting that the ethics of the practice of medicine must be guided by the religious convictions of the individual physician, I still cannot consider these subjects as areas for the field of medical ethics. The problem for the individual physician is whether or not he or she does abortions and provides information on contraception. The problem for medicine is how to arrange in a safe and economical manner to provide abortions and contraceptives for all who need them.

Drug Research. It is vital to separate the therapeutic or *possibly* therapeutic from the non-therapeutic study of drugs. Most physicians encourage their patients to participate in clinical drug testing and, even when the research is only potentially therapeutic, the most common problem is how to restrict the number of voluntary participants. As the beneficiaries of fifty years of successful drug discoveries, most physicians encourage evaluations of drugs with possible desirable effects for specific diseases. Since most patients involved in these studies are suffering from the disease that the new agent aims to alter beneficially, and since animal work will have been done previously, no ethical problems arise. If anything, I suspect that a large number of physicians would feel that the Federal Drug Administration's requirements for drug testing are much too stringent and unrealistic.

Reproductive Research. This includes artificial insemination (both donor and homologous), fetal research, in vitro fertilization, artificial placentas, and both positive and negative eugenic approaches. Problems raised by this type of study seem to be more legal in nature than medical. The general attitude of the physician is that we must continue to learn all that we can about these procedures and attempt to apply them successfully in our daily lives where indicated. Few physicians would be willing to fold their hands and wait for the genetic "end-days" without at least attempting

DR. MOORE

to solve more of the problems. It is probably here, more than on any other subject, that the ethicist and the physician would part company.

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Text: Dr. Joseph Kler
Stamp: Minkus Publications, Inc., New York

If there's good reason to prescribe for psychic tension...

When, for example, despite counseling, tension and anxiety continue to produce distressing somatic symptoms

When your patient's somatic complaints are associated with tension and anxiety and you have tried counseling and other supportive measures alone, you may decide to prescribe psychotherapeutic medication. If you do, the question remains: Which one?

Valium (diazepam) is one to consider closely. One that works promptly as an adjunct to continued supportive measures. One that generally produces significant improvement within the first few days of therapy, although some patients may require more time for a clear-cut response.

Prompt action. One good reason to consider Valium (diazepam).

And should you choose to prescribe Valium, you should also keep this information in mind: Valium is usually well tolerated; the most common side effects reported have been drowsiness, fatigue and ataxia. As with all CNS-acting agents, patients should be cautioned against operating dangerous machinery or driving. Normally, therapy with Valium (diazepam) should be continued until the patient's psychic tension symptoms have been reduced to tolerable levels.

Please turn page for a summary of product information.

Prompt action is a good reason to consider Valium® (diazepam)

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune

and Medical News

Published by Medical Tribune, Inc.

H.E.W. Sets Policy to Police Doctors

headline, *N.Y. Times*, Nov, 29, 1974

WORSHIPERS of cost efficiency, the "slide-rule boys" "computer geniuses," and management consultants in the Department of Health, Education and Welfare have been very clever. They publicly cloak each new regulatory proposal with a claim for "quality" and "efficiency" as they privately acknowledge that their prime objective is cost control of health care services—cost control of services for patients as well as the practices of physicians. First, they moved to control new drug research and the introduction of new medicines, then how the doctor should use them. They now propose, in the words of the *New York Times*, "to police" physicians' practices in hospitalizing patients.

As to future availability and flexibility of health services, look perceptively at this statement:

"The utilization review procedures spelled out in these regulations will improve the overall quality of care provided to Medicare and Medicaid beneficiaries and increase the overall efficiency of our total health care system," said Caspar W. Weinberger, H.E.W. Secretary in establishing procedures to review whether the patient's stay in the hospital is justified.

Let us note clearly that the new regulations referred to will take effect in February. They will require a review after the patient is admitted to see if hospitalization is justified. Reportedly, *"The review would be conducted on the first day by nurses and technicians. The final decision would be made on the second day by groups of doctors."* Let's face facts—the fewer the services and the shorter the hospitalization, the lower the cost. Cost efficiency, not quality of medical care, is Caspar Weinberger's specialty.

It would appear that the judgment of a patient's physician is first to be reviewed by non-physicians. Whereas nurses of necessity have had access in the past to patient's records, the government now seeks to formalize a new and massive invasion of patient privacy and of the confidentiality of the doctor-patient relationship. Traditionally, patient records have not been officially accessible without the patient's approval, even to other physicians. Now, they are to be officially opened to nurses other than those caring for the patient, to technicians, as well as to doctors other than those directly charged with the patient's care. This is a policy not only "to police doctors", it is to "police patients" by interjecting a government mandated policing body into the physician-patient relationship.

Caspar Weinberger himself lets the "cat out of the bag":

"In addition", he said, *"it is anticipated that the new regulations will save millions of dollars a year by eliminating unnecessary hospitalization and unneeded services and procedures." (New York Times,* Nov. 29, 1974, p. 19)

"Unnecessary hospitalization and unneeded services and procedures" by whose standards? Ultimately, H.E.W. standards, not those of the patient's physician.

Let us be very blunt. Caspar Weinberger's nickname (Cap the Knife) derives from cost cutting, not from surgical skill and not from improvement in quality and extent of health services.

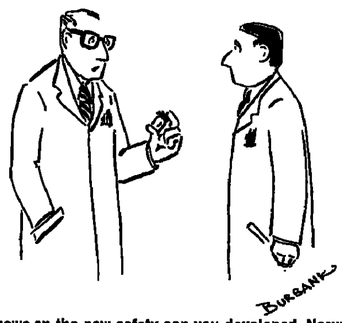
H.E.W. estimates its utilization review will produce a five-months' savings of $40 million in Medicare and Medicaid in 1975. The hypothetical savings of about $100 million a year should be viewed against the projected costs of the two federal health programs—of $20 billion for 1974. For this massive governmental intervention is thus claimed an estimate of savings, if there be any, of one-half of one percent of costs.

As is usual in such situations, nothing is said about administrative costs to supervise the program. Considering the shortage of doctors and nurses as well as technicians, can a hypothetical saving of one-half of one percent at the cost of valuable time of health professionals in short supply be justified? We have an Army, Navy and Air Force, and spend billions of dollars to protect American freedoms, one of which—confidentiality, the right of privacy—will now be sold out for the price of about two dozen Phantom jet fighters. Efforts by the Nixon administration to subvert the Justice Department, key government agencies and the Treasury Department brought America close to the brink of a new type of dictatorial control.

Astonishingly, the drive for national health insurance legislation proceeds without discussion of patient privacy and totally devoid of safeguards for the confidentiality of patients. The public and our patients should be alerted to the fact that under the cover of "utilization review," cost efficiency, and the pretense of "quality control", men from the prior Presidential administration are seeking through the regulatory actions of H.E.W. to legally breach the same physician-patient relationship whose violation in the past led to the resignation of a president.

Let's be blunt about it. "H.E.W. SETS POLICY TO POLICE DOCTORS" and proposes a program directed at POLICING PATIENTS.

A.M.S.



"Bad news on the new safety cap you developed, Nasworthy. Nobody can open it."

LETTERS TO TRIBUNE

TV Trauma Teacher

After many years of watching national TV, especially on Saturday and Sunday afternoons, I am forced at this time to voice my pentup emotions relative to the glaring errors that are repeatedly committed before millions of viewers week after week.

One doesn't have to wait for more than one full quarter of play during any collegiate or professional football game to view an injury in the making or after the fact. What usually happens, thereafter, is testimony to complicating the injury as one might compare converting a misdemeanor to a felony.

The typical case is a clipping injury with a large hulk of a player lying on the turf writhing in agony holding his knee. A trainer first runs out followed, usually, by a coach and the team physician.

The next sequence of events is what is most disturbing and probably as injurious or even more so than the injury itself. The trainer and the doctor —or more likely too, small defensive backs—come on the field to drag off a huge tackle from somewhere mid-field to behind the sidelines. Usually the injured extremity is dragging and bobbling behind unsupported and unprotected. It is quite obvious to even the untrained eye that further injury could be sustained all along the way.

Even at our junior high school level, coaches and trainers are taught to avoid further complicating an injury. A local rule is that a stretcher must be at the sidelines and an ambulance in attendance for swift delivery to the local emergency room. It is a rare sight to see a stretcher brought out on a nationally televised ballgame in order to transport an injured player properly and efficiently and avoid further insult to the damaged part.

Colleges, high schools and all down the line copy what they see and certainly professional football is the ultimate in every respect. Surely, this must be as obvious to those in positions of responsibility as it is to this observer. If management isn't too concerned about what the public sees in this regard, they must have some awareness as to the potential hazard to their major investment, namely the ballplayer himself.

My plea, at this time, is for a stretcher to be used at any time when a ballplayer cannot completely and safely navigate himself from the field of play after an injury.

PHILIP O. LICHTBLAU, M.D.
West Palm Beach, Fla.

Superb

About Dr. Alan L. Goldberg's comments in Infection Control Today (MT, Dec. 11):

Just to say *superb*, practical, clinical and purposeful. Your handling of the subject (upper respiratory infections) makes me proud of family physicians and Med Tribune too.

Your style of presentation was most enjoyable. Just believe this: You said more practical, clinical things than what I hear at symposia from the profs who do not treat patients for a fee but *honoraria.*

HARRY H. HORWITZ, M.D., F.A.A.P.
Oakland, Calif.

We're sorry we transposed Dr. Sumner Marshall's name in reporting (Dec. 25) his views on enuresis presented at the American Academy of Pediatrics' recent meeting.—Ed.

New Techniques Cut Deaths In Patent Ductus Arteriosus

Medical Tribune Report

NEW ORLEANS—A new, noninvasive diagnostic technique and a surgical protocol for ligating a patent ductus arteriosus are said to have reduced the mortality of infants at Huntington Memorial Hospital's neonatal center in Pasadena, Calif. to 10.4 per cent. The new techniques were reported here to the 40th Annual Scientific Assembly of the American College of Chest Physicians.

Dr. L. Stephen Gordon, pediatric cardiologist at the Pasadena Cardiology Medical Group, Inc., told the college that brachial arterial Doppler ultrasonography for diagnosing patent ductus arteriosus (PDA) "is a perfectly safe, noninvasive procedure that has none of the hazards of cardiac catheterization in a small, sick, premature infant." He and his colleagues, Dr. Paul E. Johnson, Hilton Buggs, and Charles Prickett, reached this conclusion after 41 tests of the Doppler technique on 38 infants with a cardiac murmur typical of PDA.

Until now, diagnosis has been made from clinical signs or catheterization, but, Dr. Gordon stated, "Previous reports . . . of the changes in the peripheral arterial pulse wave in various cardiac diseases led us to look at the peripheral arterial pulse wave in infants whom we suspected to have a patent ductus arteriosus."

Size of Shunt Indicated

The Doppler tracings, made with a directional Doppler coupled transcutaneously to the infant's skin with special electrode gel, gave dramatically different readings for forward and reverse flow velocity in normal infants and in those with suspected PDA, Dr. Gordon said. The tracings also indicated the size of the shunt. Quantitative and qualitative analysis of the data appeared to approximate the degree of left-to-right shunting through the ductus, Dr. Gordon added.

Sixteen of the infants in Dr. Gordon's Doppler tests were among the 20 operated for PDA ligation by Dr. Carter A. Printup, thoracic cardiovascular surgeon at Foothill Cardiothoracic Surgery Medical Group, Inc. in Pasadena.

"We kept accurate records to determine not only the results, but a profile of the infant that would benefit from the procedure," Dr. Printup stated. The gestation age of all the infants was 25 to 38 weeks, all revealed systolic murmur, and the average age at surgery was eight days. The new Doppler technique was used for diagnosis in a number of cases. Only those infants with progressive cardiac failure, increasing oxygen demands, and respiratory failure (despite mechanical ventilator) were operated.

Surgical Procedure

The surgical approach was through a left thoracotomy. The lung was retracted anteriorly and the ductus exposed, encircled and ligated. Halfway through the series, the suggestion was made to clip the ductus. "This was much easier than tying since, in these small infants, the exposure is understandably narrow," Dr. Printup said. "From then on, the ductus was obliterated by a hemoclip at each end."

Nonfatal postoperative complications included pneumothorax (seven cases), cerebral hemorrhage (two), pneumonia (three), and necrotizing enterocolitis and sepsis (one). Three infants died, one from a surgery-related pulmonary artery thrombus.

Dr. Printup divided the infants into three groups, in descending order of their chances of benefitting from the operation:

- Premature infants with respiratory problems caused solely by the large ductus.
- Those with the same problems who also require progressive oxygen settings to maintain adequate pO_2.
- Those with hyaline membrane disease complicated by PDA.

"Surgical obliteration of the patent ductus is definitely beneficial in the first two groups and may be so in the third group," he concluded.

Coauthors were Drs. Johnson and Gordon, Dr. William R. Dietrick, J. R. F. Penido, and B. H. Cotton.

Reviewers Welcome PBS's 'Feeling Good'

Medical Tribune Report

NEW YORK—"Feeling Good," a potpourri of entertaining features aimed at health education, premiered recently on Public Broadcasting stations around the country. The show includes segments for parents, children, pregnant women, teachers, and physicians.

The pilot show, featuring mental health, prenatal care, nutrition and emergency medical services, was reviewed for MEDICAL TRIBUNE by two specialists.

Dr. Helen Nash, associate director of the Community Mental Health Center, University of Washington, said the show's opener was "really fun to watch."

'An Up-Front Statement'

"It went down easily—really superb," she said. "Mental illness is still stigmatized to an outrageous and unfortunate degree, and I thought the program made an up-front statement about this problem. Flashing names and numbers of local specialists across the screen also made it easier for viewers to call for help if they need it."

Dr. Lee Kline, executive officer for the American Institute of Nutrition, commented on the show's nutrition segment.

"I really am encouraged by what I've seen," he said. "The subtlety of the approach was excellent and seems to be a very effective system for adult education."

"The only recommendation I would make," he added, "is more films of this type for television audiences. Nutritional problems of children and the elderly merit special attention, I think. I only hope the coverage will be extended and expanded."

The PBS series is a weekly program of 26 shows, including future segments on cancer, accidents, exercise, patients' rights and immunization. Check your local newspaper for viewing time.

'High'-Performance Driver Scores Low

Bob Bondurant, of the Bondurant School of High Performance Driving, expresses surprise at his low score after having driven a test course under the influence of alcohol in the segment "How Drinking Affects Driving."

Prize-Winning Health Series Now on National Network TV

NOW TO BE broadcast nationally on network television, MEDIX is a weekly 30-minute series on medicine and health designed to provide the public with health care information. Started in Los Angeles and produced with the cooperation of the L. A. County Medical Association and many leading health-related organizations, the series has won numerous awards and commendations in the two years since it was started. This reception led Burroughs Wellcome to decide to sponsor it nationally, starting this month. Shown are some of the scenes from the series.

"Disaster Drill," left, attempts to show how best to react to a major disaster. Above, comedian Marty Allen submits to a demonstration of month-to-mouth resuscitation.

Dr. John Boyer, of the President's Council on Physical Fitness, talks to host Mario Machado on the segment "Fitness Fun Fr All," describing how everyone can stay in shape and enjoy it.

Intractable Enteric Bacillus Menaces U.S. Burn Centers

Continued from page 1

among patients who would have been kept alive—except for the P. stuartii invasion.

When Providencia was first seen in burns in 1969, most strains were resistant to most drug therapies, Dr. Lindberg said. By 1972, this previously obscure species of enteric bacillus had acquired "total refractoriness" to all systemic or topical antibiotic therapy. The situation, he said, "is unprecedented and alarming."

Clearly, in the past number of years, there have been fluctuations in the species infecting burn wounds, Dr. Lindberg stated. "In the 1950s, staphylococci and hemolytic streptococci were major offenders while late in that decade an overwhelming preponderance of Pseudomonas aeruginosa appeared in burns." These were controlled largely by such topical chemotherapy as silver nitrate and sulfamylon.

Unexpected Rise in 5 Years

A more varied wound flora then appeared, dominated by staphylococci and fecal flora. And during the past five years, along with a rise in pulmonary complications and subsequent sepsis has been an unexpected increase in the incidence of P. stuartii.

There appears to be frequent cross-transmission from patients who have been inhospital to new arrivals. Incoming patients are found to harbor the organism within a week, "and its eradication from the burn ward thus becomes even less feasible." At the same time, Dr. Lindberg noted, patients admitted to the burn ward six to 10 days post injury are often already infected. "The proportion of positive wound swabs rose from eight per cent to 28 per cent by 1970," he said. Sputum samples rose at an even greater rate: 15 per cent were positive in 1965 and 60 per cent in 1972, with rates unchanged today.

P. stuartii is by far the most common gram-negative species in their patients. Although Staph aureus is ubiquitous on burn wounds, it has rarely been involved in patients with invasive sepsis. In addition, Providencia is the most common species recovered by biopsy of tissue beneath the burn surface, Dr. Lindberg said—55 per cent of all patients are positive. Since 1968, Providencia has consistently been the most common, predominant gram-negative species in biopsied burn wounds at the Fort Sam Houston Center.

Death Rate Reaches 72 %

As early as 1966, Providencia was the least common species in bacteremic episodes, appearing in only one of every ten patients with positive blood cultures. But, by 1970, the figure had jumped to half of the bacteremic patients. Particularly disturbing to the Texas group is that when burn patients have a staphylococcal or Pseudomonas bacteremia, fewer than 20 per cent die; when Providencia was associated with bacteremia, the fatal outcome—between 1969 and 1971—was 30 to 40 per cent. By 1973, "72 per cent of all patients with positive blood culture for Providencia stuartii died."

Post-mortem studies on a number of burn patients revealed the rampaging nature of P. stuartii. The preponderance of Providencia in lung, liver, spleen, and burn wounds in these patients was very high, Dr. Lindberg said. In contrast, in these tissues, the incidence of staphylococci was low in all sites except the wound itself. The high incidence of Providencia stuartii has continued with brief episodes of fluctuation, to the present.

"While it is not possible to ascribe to any organism an unequivocally lethal role, the results of these cultures correlated closely with a high death rate among patients with Providencia sepsis," he declared.

Almost Unstoppable

The major problem is that the organism appears, at this stage, to be almost unstoppable, Dr. Lindberg indicated. In 1969, the proportion of strains sensitive was low. "Colymycin and gentamicin showed a moderate increase in effectiveness in 1970, but then resistance increased rapidly. By 1972, there were no strains sensitive to these or any other antibiotics obtainable.

"This is a totally resistant population of bacteria. Resistance transfer factor cannot be demonstrated, but in any event, an extensive and total resistance currently permeates this important population."

Recently, a new, experimental antibiotic (amikacin) has been tested against Prov. stuartii. *In vitro*, 50 per cent of the strains were inhibited at 12.5 mcg./ml., and 25 per cent at 6.25 mcg./ml. Although they have not yet extended the study clinically, they term these results an "encouraging development."

Replay Fluoroscopy Reduces Radiation

Medical Tribune Report

LOS ANGELES—Flicker-free pseudo-continuous fluoroscopic visualization of X-ray images, with two to five times less radiation than the amount required in standard fluoroscopy, has been made possible at the University of California at Los Angeles, using a magnetic video disc recorder—the mechanism for television's instant-play and stop-action sports coverage—according to Dr. J. H. Grollman, Associate Professor of Radiological Sciences.

The technique, perfected over the last three years, consists of short X-ray pulses played back on a TV monitor at a present time interval. No X-ray pulses are needed during the replay.

"Pulse rates as low as seven-and-a-half frames per second have been used during visualization of heart arteries successfully," Dr. Grollman reported. "The instant-replay and stop-action techniques are also very helpful to the doctors in manipulating the catheters and visualizing diagnostic details," he added.

Misdiagnoses Snag Sicklemia Screenings

Continued from page 1

Many misdiagnoses, Dr. Bowman explained, result from faulty interpretation of data from electrophoretic devices that separate various types of hemoglobin on the basis of their behavior in an electric field. In some cases, hemoglobin variants, harmful or otherwise, show essentially the same electrophoretic behavior and can be misinterpreted without the proper laboratory follow-up.

It is often difficult to distinguish between a diagnosis of the sickle trait, which is essentially harmless to the carrier and B-thalassemia, a serious hemoglobin abnormality Dr. Bowman explained. Only the proportions of normal hemoglobin (HbA) and sickle cell hemoglobin (HbS) differ in the two conditions, he said, citing a case of a young man who had a history of crisis, pain, anemia, and weakness and was diagnosed as HbS. A later quantitative diagnosis showed he had B-thallasemia.

"If we had not done that diagnosis, the young man would have been considered a sickle cell trait carrier for the rest of his life and might have found his way into the literature as another example of sickle cell trait with crises," Dr. Bowman said, again emphasizing that there is no strong evidence suggesting that sickle cell carriers can expect anything other than a normal life.

A Father With 'Silent Gene'

Citing another case in which a child had B-thalassemia, Dr. Bowman pointed up the difficulties that occur when analysis showed that the mother had sickle cell trait and the father appeared to be normal (HbA). Genetically, the combination should not have produced thalassemia, but the mother insisted that her husband was the father. A second analysis Dr. Bowman said, showed that she was correct and that the father had a "silent gene" for thalassemia.

In another instance, a boy was diagnosed as having sickle cell anemia, and it was not until 4 years later, after much anxiety on his part and the part of his parents, that it was determined that the boy only had the sickle cell trait, Dr. Bowman said.

Agreeing that inadequate screening programs may be more trouble than they are worth, Dr. David Satcher of the King-Drew Medical Center in Los Angeles complained that screening for sickle cell trait is pointless if it cannot be followed up by competent genetic counseling.

Legal and Job Problems Cited

"There are just not enough physicians and adequately trained health professionals to do the kind of genetic counseling we have been saddled with since the mass screening programs were initiated," he said, noting that the misunderstanding of sickle cell trait and its implications often leads to legal and employment problems for the affected individual.

"Recently in a Los Angeles County agency, a physician had been routinely turning down all applicants for a job who had the sickle cell trait and the only way we found out about it was because of the persistence of a young woman who had applied for the position and who felt she was being erroneously discriminated against," Dr. Satcher said.

Based on a recent survey carried out in Los Angeles, Dr. Satcher suggested that as long as mass screening programs persist in their present form, those who attempt to do genetic counseling must be aware of the environment of misinformation in which the programs are carried out.

"When we talk about sickle cell trait and carrier states, the first thing that comes to many people's minds is the notion of 'Typhoid Mary' and that sickle cell trait means you are carrying some kind of an infection."

In another survey directed at physicians and health workers, 75 per cent of those queried answered erroneously that individuals with the sickle cell trait should not play competitive sports or ride air planes, Dr. Satcher said.

Good Techniques Not Enough

Dr. Satcher agreed with Dr. Bowman that as long as such misinformation about sickle cell anemia and sickle cell trait exist, even sophisticated diagnostic techniques can lead to legal or social difficulties for the person who has been screened.

"This is just another example of how laboratory science is ahead of clinical medicine and community attitudes," he said.

WHO Asks Cash, Vaccines

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GENEVA—A special account under the Voluntary Fund for Health Promotion, created this year to step up worldwide immunization programs against such childhood infections as diphtheria, whooping cough, tetanus, poliomyelitis, and measles, is seeking donations of cash and vaccines for countries in need, WHO has announced.

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The Voluntary Fund, based here and created in 1960, is used for activities beyond WHO's regular budget of $115,000,000 for 1975.

City Hospital Staff Protests Fund 'Inequities'

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NEW YORK—Disproportionate financing by the city's Health and Hospitals Corporation, long-term understaffing, and a total of $1,500,000 in cutbacks are threatening City Hospital Center in Elmhurst, Queens with "a remarkable deterioration in patient care," Dr. Stanley G. Seckler, the hospital's director, told MEDICAL TRIBUNE.

Protesting these and other inequities, Elmhurst doctors have for several weeks ceased all administrative functions, including surgical evaluations, blood bank monitoring, and infection-control checks, Dr. Seckler added.

"While other hospitals in the corporation are reimbursed $175 to $250 a day for patient care, Elmhurst gets $150," he explained. "In addition, unlike other city hospitals, we have always returned any unspent budget money to the corporation and have gotten city contracts based on the amount spent the year before, even though our patient load has increased remarkably. Mandatory increases from the city are also a percentage of base expenditures, so we've been losing money all along."

Problem of Budget Gap

According to a spokesman for the Health and Hospitals Corporation, however, Elmhurst is not the only one of the 19 city hospitals affected by the billion-dollar budget gap. "A total of $15,000,000 has already been cut from our annual budget," the spokesman said, "with more pressure from the mayor to lop off another $26,900,000—and to fire 551 provisional staff personnel."

Dr. Seckler described the situation as "ridiculous."

"Reimbursement from third-party insurance comes into the corporation much faster than we get paid. A good part of it is being sequestered by the city and may be going to support the sanitation department or to maintain the 35¢ [bus and subway] fare," he complained.

"In a sense, the city is profiteering with the infirm and the sick of New York. If all the money collected were returned to the hospital, we would have more funds for adequate staffing and patient care programs."

Elmhurst's executive director Dr. Jack Koretsky added, "No major services will be cut, but we'll be squeezed all year."

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"The situation right now is grim, but it is making us identify our objectives anew and forcing us not to be tied down by academic inertia."

Montreal Team Relates 2 Cases Of TV Epilepsy

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OTTAWA—Montreal investigators described the cases of two girls with self-induced television epilepsy. The seizures are induced by coming up to within a few inches of the TV screen.

Both patients began their clinical history in childhood (ages 10 and seven) with petit mal absence attacks. Generalized seizures later appeared spontaneously, with self-induction developing secondarily.

Both patients show typical primary generalized corticoreticular epileptogenic abnormalities and extreme sensitivity to photic stimulation. In both, seizures progressed to generalized tonclonic attacks, which are almost never seen in self-induction with hand waving, the investigators said. Both reacted favorably to drug treatment in terms of seizure control, but were irregular in taking medication.

From Disturbed Families

Both came from disturbed families with disrupted parental relationships. Seizures were almost always induced when the patients were alone, in situations of guilt and/or frustration. Following these seizures the patients describe a feeling of relief of previous psychological tension and of having temporarily escaped from a painful reality, the team said.

The investigators suggested that the seizures are an escape mechanism in highly photosensitive and emotionally predisposed individuals. The patients have a need to keep self-induction a secret, they noted.

The report has presented by Drs. Pierre Clement, Frederick Andermann, and Maurice Dongier, of Montreal Neurological Hospital and Allan Memorial Institute, McGill University.

In commenting on their patients, they asked:

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One Man...and Medicine

ARTHUR M. SACKLER, M.D.,
International Publisher, Medical Tribune

Is There Only One True Science? RESEARCH AND PATIENTS' RIGHTS - PART II

There are those for whom issues are more important than individuals. Such may be the case at hand in regard to the present attack on XYY chromosome research.

A group of Boston "scientists" calling themselves "Science for the People", among whom physicians and clinicians are noteworthy by their absence, have charged that studies of children with extra sex chromosomes are unethical, unscientific, and potentially harmful to the children, that they can cause parental anxiety and other problems. It has been pointed out that the XYY chromosomal pattern has been reported to occur in higher frequency in mental and penal institutions and that a notorious murderer was incorrectly reported as having the XYY karotype. Thus, those very "scientists" who raise the question of the "unfair identification" of individuals with different chromosomal make-up are perpetuating the very conditions which they say "jeopardize" those they claim to protect by recirculating inaccurate reports and by suggesting that nothing can be done for individuals with different chromosomal patterns. Let us examine the ultimate implications of their position.

Folly of Stopping Tests

Let's assume that a simple urine test done shortly after birth could prognosticate future schizophrenia or malignancy. Should such a test be stopped on the grounds that we do not have good enough therapies for either the schizophrenias or the malignancies —therapies that would satisfy such groups as "Science for the People"? Should such tests be interdicted by law because they would cause parental anxiety and concern? Or, should such tests be done without informing the family, thus violating "full disclosure" and "informed consent"? Or should press freedom be suspended to "protect the people" from either misinformation or anxiety?

And what about terminal malignancy? Will "Science for the People" sue on the basis of their "logic" to prevent physicians from informing patients on the grounds that the presence of an incurable disease should interdict the physician's "creating" patient anxiety? Can "Science for the People" create by legislation more sensitive procedures than our present practice of the physician's selectively deciding what a patient can or cannot "tolerate" in respect to life and death?

Mocking "Full Disclosure"

And what about "Full Disclosure"? Is that right now to be restricted only to conditions for which they are remedial measures? It would seem to make a mockery of the term.

What is "Informed Consent" to be? What is the significance of "Informed Consent" if participation in research procedures is first to be determined upon a class basis by law rather than on an individual basis by choice—no right to research participation for prisoners, mental patients, now XYY children—and what next?

And what about *my rights—my right* to have my children participate and benefit from the fruits of new research and new knowledge? Can "Science for the People" preempt my rights; can they as a group take precedence over my rights as an individual to participate in a research cohort?

The Cloaked Attack

Is not "Science for the People" a misnomer or a cloak which hides another intent? I have noted increasing attacks on biologic science by those who believe that social, economic, and environmental factors are the primary or sole determinants of disease and social deviancy. The extremity of such claims for social and environmental etiologies should be examined.

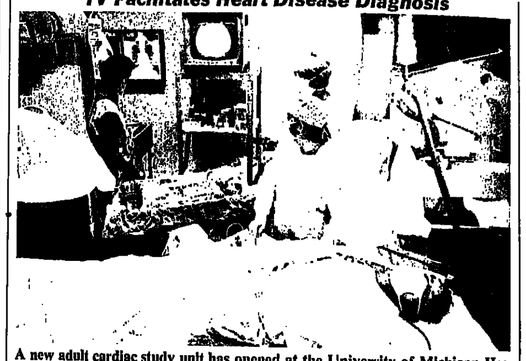
Perhaps it is pertinent to point out that no group, certainly no publication, has matched MEDICAL TRIBUNE as it fought against environmental pollution before the word "ecology" became common; its campaigns for auto safety well before Nader became known; its attacks on addiction to alcohol and cigarettes as two of the commonest preventable causes of disease and death; and its support of all measures to improve nutrition and housing as essential substrates for good health.

True "Science for the People"

If we are to have a true "Science for the People," then we need both better social conditions and more and better science—not one in place of the other. To pit social needs versus science is a disservice to both; it is a disservice to "people" as well as science. To expose scientists once again to vicious attacks based on dogma is to have us borne back to the "Dark Ages" before the "Age of Enlightenment" by a new breed of Inquisitors —neither Grand, nor church appointed, but immodestly self-annointed. Responsible individuals, organizations and organs of science must promptly address the growing number of attacks on its members and its methods, lest both be subverted by an "anti-science" cloaking itself in the mantle of the "only true" science, claiming for itself the only "legitimate" expression of science, "Science for the People."

We cannot say it often enough— *"Anti-Intellectual means cannot be justified by proclaimed social ends."*

TV Facilitates Heart Disease Diagnosis



A new adult cardiac study unit has opened at the University of Michigan Hospital. Here, doctors are seen reviewing a video tape showing injection of a contrast medium into a patient's heart. This form of "instant replay" allows cardiologists to know immediately if the x-ray study has been effective or will have to be repeated.

Tobacco, Marijuana Smoke Inhibit Macrophage Action

Medical Tribune Report

NEW ORLEANS—Animal experiments with pulmonary alveolar macrophages suggest that, in terms of susceptibility to bacterial infection, marijuana smokers—an estimated 25,000,000 of them in the United States—would do well to use a water pipe.

Dr. Gary L. Huber, Assistant Professor of Medicine at Harvard Medical School, reported to the 40th Annual Scientific Assembly of the American College of Chest Physicians here on experiments at Beth Israel Hospital, Boston, with such macrophages taken from rats by bronchopulmonary lavage.

The macrophages were mixed with bacterial suspensions of Staphylococcus albus and humidified smoke from the National Institutes of Health reference marijuana units, from tetrahydracannabinol-extracted marijuana placebo cigarettes, and from reference Kentucky tobacco cigarettes, and viable bacteria were subsequently counted.

Bactericidal Activity Depressed

Control macrophages not exposed to any smoke reduced the number of living bacteria to 26 per cent within three hours of incubation. But both tobacco smoke and marijuana smoke depressed essentially all bactericidal activity of the test macrophages: 83.3 per cent of the Staph remained viable over the same three-hour interval when the mixture was exposed to tobacco smoke, and a similar proportion survived in the marijuana condition.

Dr. Huber's team also investigated the effects of stale versus fresh marijuana and tobacco smoke in the same system.

"Whatever the potential cytotoxic ingredient present, it was found only in fresh smoke," Dr. Huber stated. "Delay of delivery of the smoke to the tissue culture flash removed or altered macrophage cytotoxin."

Again, no discernible difference between tobacco and marijuana smoke could be established, he noted.

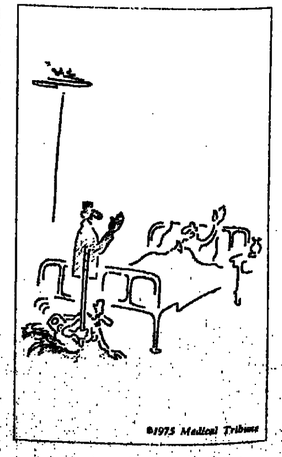
Use of an absolute filter disk to remove all particulate matter from the marijuana smoke, producing a pure filtered gas phase of the smoke product, did not change the results.

"The gas phase depressed macrophage activity in a manner comparable to whole smoke," Dr. Huber reported.

But "filtration of this gas phase component through water removed the macrophage cytotoxin, resulting in no impairment in macrophage activity," he said.

Further studies strongly suggested that tetrahydracannabinol, the principle psychoactive component of marijuana, is not the cytotoxin in question, Dr. Huber said. Eight ml. of whole marijuana smoke impaired macrophage function is essentially the same degree as 8 ml. of smoke from THC-extracted marijuana placebo, and the further addition of a proportionate amount of purified THC had no effect on alveolar macrophage function.

Other members of the research team were Mary Beth Cutting, S. Goodenough, A. Watson, G. Simmons, and Dr. Raul Laguarda.



EDITORIAL CAPSULES

. . . brief summaries of editorials or comments in current medical and scientific journals.

Exercise and the Heart

"None of the . . . data prove that exercise training can alter the development of ischemic heart disease or help patients with established coronary artery disease. However, recent reports on the use of exercise in diminishing the incidence and severity of angina pectoris have been promising. The mechanism of response of angina to exercise training might involve reductions in the reactions of the heart rate and the arterial pressure to exercise, possibly enhanced myocardial oxygen delivery, and a decreased cardiac output for a given amount of exercise . . .

"Exercise training can improve the claudication distance in patients with peripheral vascular disease. If it be accepted that the pain of intermittent claudication is similar in its pathogenesis to that of angina pectoris, then the effects of exercise on intermittent claudication also argue for exercise training in patients with angina pectoris. Exercise training in man is accompanied by metabolic alterations in peripheral muscle; there are increments in the size and oxygen uptake of peripheral muscle mitochondria as well as in the overall tissue contents of glycogen, glycogen synthetase, and hexokinase. . . .

"Exercise programs have also been used to help rehabilitate patients after myocardial infarction . . . Exercise is not without dangers and the physician advising exercise as either a therapeutic or diagnostic procedure has definite medicolegal responsibilities. The presence of emergency defibrillation equipment during training sessions is held to be essential by some workers. . . ." *(Editorial, Lionel H. Opie, M.D., Amer. Heart J. 88:539, Nov. 1974)*

Drugs and Diets

". . . If a fraction of the attention devoted to assessing new drugs was turned on to diets, it could reap handsome rewards for the science of therapeutics. . . . Too many attempts to investigate dietary treatment have been so poorly controlled that the results would not have been published if they had referred to drugs. Moreover, investigations of the contribution of diet to disease have a potentially important preventive role. Burkitt, Cleave, and others have stimulated thought about diseases which may have been caused by one form of dietary deficiency—lack of fibre, and its replacement by refined carbohydrate. Their postulates now need exact evaluation, and many doctors are properly concerned about the obesity epidemic which is spreading from the U.S.A. to Great Britain, let alone the complicated questions about diet in prevention and treatment of degenerative arterial disease. Perhaps a subsection of clinical pharmacology devoted to diet and disease needs to be founded. Just as with drugs, for dietary prescription the best guide is do no harm." *(Editorial, The Lancet 2:994, Oct. 26, 1974)*

Home Culturing of Urines Helpful in Children

Medical Tribune Report

SAN FRANCISCO—Home culturing, using the roll-tube technique, has proved to be an economic and efficient method of checking the urines of children with recurrent bacteriuria for the presence of infection.

Dr. Robert Fennell, of the Shands Teaching Hospital, Gainesville, Fla., said that parents can be taught to obtain clean-catch midstream urine, as well as bladder and ileal-conduit specimens by catheterization if necessary; to culture the urine at home; and to count the number of colonies in the culture.

At his institution, 350 patients with a history of recurrent infections have been participating in such a program, he reported. Cultures are done weekly following an infection and monthly if a patient has been infection-free for eight weeks. Home culturing is supplemented by clinic visits every two to three months.

2nd Home Culture If Positive

When a home culture is positive, a second culture is done before a clinic culture. Clinic cultures have been positive for the same organism found in two positive home cultures 65 per cent of the time, Dr. Fennell said, and 5 per cent of cultures negative at home have been positive in the clinic.

The home screening appears to have detected a "significant number" of infections that otherwise might have gone undetected, he commented. The method can be substituted for prophylactic antibiotics, while the physician maintains control of the situation, he added.

Parental involvement is a significant factor in the success of such a program, Dr. Fennell went on. Both the patient and the parents assume a sense of control and responsibility for the disease, realizing that urine infections can lead to chronic pyelonephritis and severe kidney disease, he said.

The home culture program was the subject of a scientific exhibit at the American Academy of Pediatrics meeting here. Drs. R. D. Walker, E. H. Garin, and G. A. Richard, and Sandra Austin collaborated on the exhibit report.

Vitamin Extends Fibroblasts' Life In Tissue Culture

Medical Tribune Report

SAN DIEGO, CALIF.—New evidence that vitamin E can almost double the life span of human fibroblasts in tissue culture was presented at the 14th Annual Meeting of the American Society for Cell Biology in Cell Biology.

When the fibroblasts were grown in the presence of from 10 to 100 micrograms of vitamin E (tocopherol) per ml. of medium, the cell populations divided about 100 times. That compares with the approximately 50 cell divisions normally expected before the same kind of cells stop multiplying, according to Dr. Lester Packer, University of California, Berkeley, and Dr. James R. Smith, Veterans Administration Hospital, Martinez, Calif.

"In tocopherol-treated cells at the 97th passage level, about 95 per cent of the cells are capable of synthesizing DNA, which suggests that their cells are capable of many more population doublings. Furthermore, growth of cultures for 30 population doublings in the presence of tocopherol also confers at least 30 additional population doublings to their in virto life span," they said.

In addition, they said, the older cell populations treated with vitamin E were morphologically similar to the younger cells from which they descended.

Effect on Oxidation Damage

It is possible, although not yet proven, that the tocopherol may have in some way interfered with the build-up of oxidation products, as appears to happen in aging cells, Dr. Packer suggested in an interview. When he and Dr. Smith exposed fibroblasts to the environmental stresses that would produce such oxidation damage, including visible light and high oxygen levels, they found that tocopherol seemed to "slow the occurence and accumulation of oxidative damage such that the growth potential and survival of human fibroblasts in vitro is enhanced."

Asked whether or not the Berkeley experiments provide support to those who claim that large doses of vitamin E increase human lifespan, Dr. Packer refused to speculate.

"There is a different mechanism of aging at every level of biological organization, and aging in one type of cell in tissue culture cannot be equated with the aging process in humans," he said.

In a companion paper, Dr. Alexander Sun, also of the University of California at Berkeley, reported that there was a sharp increase in the concentration of three different enzymes as human cells aged in tissue culture. He found that the activity of cytochrome oxidase increased 300 per cent in aging cells, N-acetyl-glucosaminidase doubled, and 5-nucleotidase increased by as much as 100 per cent.

"The striking increases in 5'-nucleotidase may be related to ATP metabolism and to other work in this laboratory (Packer's work) showing that vitamin E reduces the accumulation of oxidative damage and markedly extends cell life span," Dr. Sun said. Co-author was B. B. Aggarwal.

Tribune Economic Analysis

2 Suggestions For Cost Cutting By the Airlines

BY ELIOT JANEWAY
Economic Consultant

With costs continuing to spiral, the airlines' only hope of rebuilding traffic is to offer bargains in fares. The only route to fare-cutting is by cutting back on services. This raises the fear that the services most likely to be cut will be maintenance and repair. But the only change coming in airline maintenance budgets is on the up side. Looking for places to cut goes back to defining what business the airlines are in and what they are not in. Affluence encouraged the airlines to use the psychology of getting something for nothing. It also caused them to confuse the air-shuttle game with some kind of flying substitute for posh restaurants.

The airlines could effect really meaningful savings if they could get rid of their catering burden on all but their longest flights. Even relief from the cost of printing their chichi menus would help.

Cutting back on the bar and restaurant, and offering a cash saving to passengers would make a difference. Suppose, when all the smoke cleared away, paring down food services netted an average saving of $15 a ticket. And suppose the airlines split it with their passengers. This would give them better advertising than all the efforts they could make in posh dining.

Another experiment they might try is telling passengers about the high cost of handling baggage. Offering an incentive discount to passengers who use the space in the cabin instead of in the hold would yield a dollar to split both ways, too.

Despite today's high mortgage interest rates, is this the time to invest in income real estate, specifically the new garden apartment projects that have not been rented yet?
Dr. E.J., St. Louis

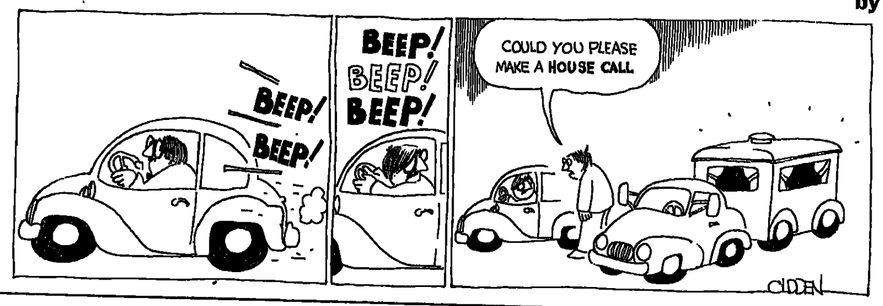
There are worse things you might do with good money, but I cannot think of them. New investment in income property today buys the worst of both worlds—costs too high to be absorbed by the present level of rents, and rents too low to absorb the present level of costs. Potential tenants are running out of rent-paying power faster than landlords are running out of tenants.

Will the government antitrust suit at AT&T force its stock down? What will happen if the government wins?
Oklahoma Physician

It already has. A disaster that will make the present state of affairs and present interest rates seem to hindsight like tranquil times. Providentially, however, I don't see any chance that the government can win, and I do see considerable chance that it will recognize its blunder and save face before its suit does any more damage to our battered markets.

Clinical Trials

by Oldden



TRIBUNE SPORTS REPORT

Middle-Aged Joggers Show Healthy Lipoprotein Pattern

Medical Tribune Report

DALLAS—The vigorous middle-aged male jogger achieves and maintains a lipoprotein pattern that not only is distinctively different from that of his sedentary peer, but also "might be mistaken for that of a typical younger woman," the American Heart Association was told here.

In fact, the fasting plasma lipoprotein distribution in such men is one that is "considered by most authorities to be conducive to heart health," according to Dr. Peter D. Wood, Adjunct Professor of Medicine and deputy director of Stanford's Heart Disease Prevention Program.

In detailing what is believed to be one of the first studies to measure plasma total cholesterol and triglycerides in long-distance male runners and in randomized controls, Dr. Wood said the joggers, aged 35 to 59, had significantly lower plasma low-density-lipoprotein (LDL) and significantly higher high-density-lipoprotein (HDL) cholesterol levels than the controls. The HDL/LDL ratio was higher in runners, total cholesterol was "modestly lower," and plasma triglycerides were "strikingly lower" in the active group.

15-Mile-a-Week Joggers

The findings were made in a study of men in northern California who had jogged an average of at least 15 miles a week for the preceding year. Dr. Wood stressed that most were not lifelong athletes, and "a number of them reported taking up running in their late 30s or 40s at a time when they were unfit, overweight, and cigarette smokers." At the time of the study, all had stopped smoking and were reasonably lean, with a mean body fat content of 13 per cent.

The controls consisted of 743 randomly selected men, aged 35-59, who were measured for fasting plasma total cholesterol and triglycerides, and a subgroup of 137 men who were also measured for plasma HDL and LDL cholesterol levels. Dr. Wood noted that the controls were predominantly men of relatively sedentary habits.

All blood samples were drawn in the morning, following a fast of 12-16 hours. The runners were asked not to do any vigorous exercise during the fasting period, so that the values shown were not immediately after exercise.

For every age group in the study, triglycerides levels were "much lower" for the runners, Dr. Wood reported. For the total group, the runners "had less than half the mean triglyceride concentration of the controls (70 versus 146 mg. per cent)."

Plasma HDL concentration in the joggers showed a mean of 65 mg./100 ml., compared with 43 mg./100 ml. for controls, and plasma LDL cholesterol levels in the active group were a mean of 125 mg./100 ml., compared with 139 mg./100 ml. in controls. The HDL/LDL cholesterol ratio in plasma was thus "considerably higher" in the runners, with values at .52 compared with .31 for controls.

"We conclude that our middle-aged runners have plasma lipoprotein patterns that are quite different from those of average, generally sedentary men of the same age from nearby communities," Dr. Wood commented. "In fact, the runners' patterns, with a low VLDL (very-low-density lipoprotein) level, a high HDL level, and relatively low LDL level, might be mistaken for that of a typical younger woman."

Adiposity Not Important

He emphasized that regression and correlation studies, in both the joggers and the control group suggested that adiposity "is not a very important variable in seeking an explanation for the pronounced lipoprotein differences between runners and controls. Although our study does not establish it, we feel it most likely that the greatly increased exercise level of the runners is by itself the major factor responsible for the advantageous plasma lipoprotein pattern observed in this small but rapidly growing group of very active middle-aged men."

Coauthors were Herbert Klein, Steven Lewis, and William L. Haskell, Ph.D. N.H.

Vasopressin Trial Urged Before Knife For Marginal Ulcers

Medical Tribune Report

SAN FRANCISCO—Vasopressin infusion should be given a trial before surgery is attempted for bleeding marginal ulcers, according to Dr. Seymour Sprayregen of New York.

He told the American Roentgen Ray Society that vasopressin infusion in the superior mesenteric artery halted or slowed bleeding in three patients with bleeding marginal ulcers diagnosed by superior mesenteric arteriography.

In one patient, vasopressin infusion stopped bleeding immediately. In a second, the infusion stopped the bleeding but rebleeding occurred when the infusion ceased, so that the infusion was resumed until the patient stabilized and was treated surgically. In the third, control was transient and the patient was treated surgically.

Dr. Sprayregen noted that vasopressin is widely accepted for variceal and superficial mucosal bleeding of erosive gastritis and Mallory-Weiss lacerations, but that its effectiveness has not been demonstrated in bleeding marginal ulcers.

He suggested a dose of 0.4 units a minute might be more effective than the 0.2 units a minute used in his patients.

Lung Association Unveils New TB Classifications

Medical Tribune Report

NEW YORK—The American Lung Association has released new classifications for tuberculosis.

"Twenty years experience with anti-TB drugs proves that adequate chemotherapy can cure, rather than just arrest, TB," said Dr. John G. Weg, Professor of Internal Medicine at the University of Michigan. "Because TB no longer is a disease with a lifetime of flareups and remissions, the patient can be discharged from care, with TB records becoming a part of the medical history, just like any other condition from which he or she has recovered."

Dr. Weg chaired a committee of the American Thoracic Society which prepared the new edition of *Diagnostic Standards and Classifications of Tuberculosis*, the standard reference on TB, in which the new classifications appear.

The new classifications are:

- **No tuberculosis exposure, not infected.** No history of exposure, negative tuberculin skin test.
- **Tuberculosis exposure, no evidence of infection.** History of exposure, negative tuberculin test.
- **Tuberculosis infection, without disease.** Positive tuberculin skin test, negative bacteriological studies (if done), no X-ray findings compatible with tuberculosis, no symptoms due to tuberculosis.
- **Tuberculosis: infected, with disease.** The current status of the patient's tuberculosis is described by three characteristics: location of the disease, bacteriological status, and chemotherapy status. For some patients additional characteristics—X-ray findings and tuberculin skin test reaction—would be included.

Alan Guttmacher Institute

Medical Tribune Report

NEW YORK—The Planned Parenthood Federation of America has formed the Alan Guttmacher Institute to serve as its research and development division. Dr. Guttmacher, who died last April, had been federation president for more than 10 years. The institute's national council will be headed by Dr. Philip R. Lee, former Assistant Secretary for Health and Scientific Affairs.

IMMATERIA MEDICA

By DUDLEY STRAUS

More Odds, More Ends

• In case you want to know what they're reading in college these days, the literature seems to include *Hulk, Spider-Man, Werewolf by Night, Iron Man, and Man-Thing.*

We've picked up this bibliographic information from an order form that, for reasons unknown, landed on our desk, hot from Marvel Comics. The form lists 36 of these gems of literature and art, and bills them as the "College Student Comic Line." Anyone who places an order is supposed to let old Marvel know if he's an undergraduate or a graduate student.

• A Reuters dispatch in the *Washington Post* reports an Australian solution to one of the problems of the Age of Communication:

"CANBERRA,—A government organization has found a new use for its reports—feeding them to sheep.

"Research scientist Dr. Barry Coombe, of the Commonwealth scientific and industrial research organization, has been using old printed reports as part of an experimental diet for sheep, and the latest bulletin says they are thriving."

• The zippiest lead sentence we've seen in many a day began a release from the University of Minnesota:

"'scuse me a second doctor, got some business," the girl said, running onto the hospital ward and breaking off the end of a pop bottle. Then she joined another patient who was engaged in a fight with a member of the hospital staff."

• An amazing number of publicity releases touting new examples of good-old-American-know-how cross our desk. For once, we've been taken aback by a notice pushing a "new invention" that may be less absurd than most.

Its name is *Backbrief*, and it's a padded tapered attaché case that you stick behind your back while driving, flying, or sinking into the family sofa. It's said to be no good for the very obese who need the whole seat for themselves.

• "A U.S. certified, registered, licensed midwife [who] has delivered over 3,500 bundles of joy," and who is named Norman Casserley, has petitioned a Houston, Tex., court to change his name to Mister Midwife, we are informed by a news release from the International Association for the Advancement of Lay Non-medical Midwives. Will his nephews call him Uncle Mister, we wonder.

• If necessary, eat this item to prevent it from reaching your children, for, according to United Press International, a Dr. Rudolf Link, of the Hamburg (West Germany) Ear, Nose, and Throat Clinic, states that children who refuse to wash their ears may be right: "Ear wax is not dirt. It protects the drum of the ear. There is no place for soap and water in these sensitive organs," he says.

Psychosomatic Illness Seen Getting Psychiatric Spotlight

Medical Tribune World Service

ST. URBAN, SWITZERLAND—Psychosomatic illnesses, neurosis, and drug addiction will be the major preoccupations for psychiatrists 10 years from now, according to an opinion survey in Germany, Austria and Switzerland.

Asked which scientific discipline is most likely to assist in the progress of psychiatry, many respondents (46 per cent) said biochemistry. Next was pharmacology (24 per cent), then sociology (14 per cent), but only 11 per cent replied depth psychology.

The poll, described at the annual meeting of the Swiss Association of Psychiatrists at the St. Urban psychiatric Clinic, near Bern, by Dr. Walter Poeldinger, found pharmacotherapy regarded as the major therapeutic trend of the future, with a vote of 58 per cent. Social therapy scored 24 per cent and psychotherapy only 9 per cent

Dr. Poeldinger said that those questioned included 234 psychiatrists, 111 physicians not practicing psychiatry, and 78 non-MDs. The last consisted of 21 psychologists, 21 research scientists, and 36 sociologists and social workers.

Asked about organizational structure, the majority of psychiatrists replied that by 1985 the big, centralized psychiatric hospital will have been replaced by psychiatric wards attached to general hospitals.